BlueCross BlueShield
Federal Employee Program

KORLYM
PRIOR APPROVAL REQUEST

Send completed form to:

Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER COMPLETES

Date: ____ / ____ / ____

Cardholder Name: _____ / _____ / _____
First MI Last

Patient Name: _____ / _____ / _____
First MI Last

Patient Address: _____
Street

_____
City State Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ____ F ____ **R** |_|_|_|_|_|_|_|_|_|
Cardholder Identification Number

PHYSICIAN COMPLETES

KORLYM (mifepristone)

NOTE: Form must be completed in its **entirety** for processing

1. Diagnosis for which this medication is being prescribed:

- ❑ Cushing's Syndrome *(if checked, please select the type)*
  - ❑ Endogenous Cushing's Syndrome
  - ❑ Exogenous Cushing's Syndrome
  - ❑ Other (*please specify*):_____
- ❑ Other *(please specify)*:_____

2. Does the patient have a diagnosis of Type 2 diabetes? ❑Yes ❑No*

*If No, is the patient glucose intolerant? ❑Yes ❑No

3. Has the patient failed surgery or is not a candidate for surgery?

- ❑ Yes – patient has failed surgery
- ❑ Yes – patient is not a candidate for surgery
- ❑ No – the patient has neither failed surgery and is a candidate for surgery

4. If the patient is female, is the patient currently pregnant? ❑Yes ❑No

The information provided on this form will be used to determine the provision of health care benefits under a U.S. federal government program, and any falsification of records may subject provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification.

Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

_____ (_____) _____ (_____) _____
Physician Name (Print Clearly) Phone Fax

_____ _____ _____ _____
Street Address City State Zip

_____ _____ / _____ / _____
Physician Signature Date